AND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decased lived, If institution: Residence before admission) si director. Page for your files. a. COUNTY of Health. a. STATE b. COUNTY Charles Marvland MARYLAND Charles b. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporeta limits, write RURAL and give nearest town) write RURAL and give nearest town) (Rural) LaPlata, Md. Dentsville, Md d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Physician's Memorial Hospital ould be executed within 24 hours after death. If any in pencil in Item 18. Give Pages 1, 2, and 3 to the function of the form PM3. Page 5 may be retained burial-transit permit. File pages 1 and 2 with 1% (rate forms) and in any event within 72 hours efter feath. YES A NO T 3. NAME OF 4. DATE Middle Month Year DECEASED (Type or print) DEATH 19 66 18 STANLEY LEROY BARBER 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. Oct. 14.1965 last birthday) male negro WIDOWED [ DIVORCED 3 10 USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona Muring most of working life, avan if ratired U.S.A. Marbury . Maryland Infant 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Evelyn Barber Sunny Price 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yas, no, or unkown) | (If yas give we ror dates of service) Evelyn Barber-Mother-Dentsville, Md. Office elong with burial-transit permi None 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Hydrocephalas Pneumonitis due to aspiration of IMMEDIATE CAUSE (a) This certificate should be Old/thrombosis/of/dural/singles food due to Conditions, if any, which congenital malformation of brain "pending" gave rise to immediate cause Ø Medical Examiner's (e), stating the underlying (megalocephaly with microgyria) o be used cremation, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION PERFORMED? lease execute ... certificate, writing the word should be forwarded to the Chief Medical E. FUNERAL DIRECTOR: Page 3 should be r its designated agent, prior to burial, cremati "Old thrombosis of dural sinuses" YES -NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enlar nature of injury in Part I or Part II of item 18.) PRIMARY [] or CONTRIBUTING CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Homa, farm, ! Month, Day, Yaar 20d. INJURY OCCURRED 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While Not While et work at work 21. I certify that I took charge of the remains described above, held an Autopsy XI, Inspection Inquiry and in my opinion CAL designated agent, death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER X DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER 1-19-66 EXAMINER'S Rudiger Breitenecker, M.D. NAME (Type) Address (Streat, city, town, or county) 22a, BURIAL, CREMATION, 22b. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) Sacred Heart Cemeter 1/21/1966 La Plata . Maryland 940 23. FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VS. A15ME Arehart Funeral Home, Inc .- La Plata, Md. JAN 5M 7/59 189082

Item 18 Film G373

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

maryland state department of health division of statistical research and records, 301 w. preston street, baltimore 1, maryland certificate of death

| 1.            | PLACE OF DEATH a. COUNTY   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Res                     |   |  |  |  |
|---------------|--|---|---|--|--|--|
|               | Charles MARYLAND   | LISTATE DELL'AND B. COUNTY St. Lucie  |   |  |  |  |
|               | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  La Plata   | c. CITY OR TOWN (It outside corporate limits, write RURAL a                       | and give nearest town)                  |  |  |  |
|               | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   | d. STREET ADDRESS   | e. IS RESIDENCE                         |  |  |  |
|               | Physicans Memorial Hospital  | 1928 Eucalytus Street   | YES NO A                                |  |  |  |
| 3.            | NAME OF DECEASED (Type or print) CAROL KROLL BOH.  | A STETUS 4. DATE OF Month OF DEATH OF THE 2                                       | Day Year 8 1966                         |  |  |  |
| 5.            | SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   8  | B. DATE OF BIRTH   9. AGE (In years   IF UNDER 1                                  |   |  |  |  |
|               | White WIDOWED X DIVORCED   | Dec. 7, 1892   73 yrs.  | Days Hours Min.                         |  |  |  |
| 1D:           | a. USUAL OCCUPATION (Give kind of work done lob. KIND OF BUSINESS OR INDUSTRY  | COL   | IZEN OF WHAT                            |  |  |  |
|               | Supervisor-Retired U.S. Commerace  |   | S.A.                                    |  |  |  |
| 13            | . FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME  |   |  |  |  |
| 13            | William Kroll  | Minnie Kroll  |   |  |  |  |
| 15            | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. es, no, or unknown) (If yes give war or dates of service)         | INFORMANT Addr ort  | Tobacco,                                |  |  |  |
|               | No   313-18-1582 I   | Mr. Gerald E. Foreman-Son   | ,Md.                                    |  |  |  |
|               | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  | 1   | ONSET AND DEATH                         |  |  |  |
|               | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  ORLEGAL  | flerror de age  | 2 days                                  |  |  |  |
|               | 38/X DUE TO  |   |   |  |  |  |
|               | Conditions, if any, which (b)  |   |   |  |  |  |
|               | gave rise to immediate cause (a), stating the DUE TO   |   |   |  |  |  |
|               | underlying cause last. (c)   |   |   |  |  |  |
| CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA   | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)                          | 19. WAS AUTOPSY PERFORMED? YES NO X     |  |  |  |
| CERTIF        | 20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCU<br>OR CONTRIBUTING   CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | RRED. (Enter nature of injury in Part I or Part II of Item 18.)                   |   |  |  |  |
| MEDICAL       | While I Not while I  | CE OF INJURY (Home, farm,<br>ry, street, office bldg., etc.) (City or town) (Cour | nty) (State)                            |  |  |  |
| Z             |  | 13 15 016 1-38 00   | Z 11 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |  |  |  |
|               | 21. I certify that (I) (this hospital) attended the deceased from  |   | 2, that (I) (we) last                   |  |  |  |
|               |  | death occurred at M, from the causes and on th                                    | e date stated above.<br>TE SIGNED       |  |  |  |
|               | 22a. SIGNATURE ADMINISTRATION M.D  | ATTENDING MED. STAFF  | P-66                                    |  |  |  |
|               | 22c. PHYSICIAN'S NAME (Type) F.M. Johnson , M.D.   | La Plata , Maryland   |   |  |  |  |
| 23            | a. BURIAL CREMATION, 23b. DATE THEBEOF 23c. NAME OF CEMETERY Kankakee Me   |   | nty) (State)<br>linois                  |  |  |  |
| 24            | I. FUNERAL DIRECTOR ADDRESS  | 25a. REC'D BY REGISTRAR   25b. REGISTRAR'S  | SIGNATURE                               |  |  |  |
|               | Arehart Funeral Home, Inc La Plate   | a, Md. DAFEB 4 1966 Acharle   | Judge                                   |  |  |  |
|               |  |   |   |  |  |  |

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| ell. Dar ent hachakes , Illin ober   |                  |  |

RYLAND STATE DEPARTMENT OF HEALTH 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. COUNTY b. COUNTY 42 MARYLAND b. CITY OR TOWN (if outside corporate limits, and c. LENGTH OF STAY IN 16 (If outside corporate limits, write RURAL and give þ write RURAL and give negrest town) 72 hours after .⊆ Pages filled i OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) completely executed NAME OF First Last DATE Month DECEASED OF (Type or print) = DEATH and cor 6. COLOR OR RACE 7. MARRIED AGE/In years | IF UNDER 1 YEAR 9. per hithday) Months WIDOWED DIVORCED The law requires that the death certificate physician 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ratired) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? remove 13. FATHER'S NAME please attending 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unkown) | (Ifyesgive war or dates of service) 9367MISS permit. 18. CAUSE OF DEATH Enter only one cause par physician. signed by PART I. DEATH WAS CAUSED BY ō IMMEDIATE CAUSE (a) attending has been gava rise to immediate cause DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. certificate CERTIFICATION the hospital 35 0 esn prior 2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.) Por OR CONTRIBUTING CAUSE OF DEATH After this 2De. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20f. (City or town) lactory, street, office bldg., atc.) Whila Not Whila Hour a.m. jo at work at work p.m. KECTOR: (this hospital) attended the deceased from 1706. .....1966, and that death occurred at 1.58M, from the causes and on the date stated above deceased alive saw the 22a, SIGNATUR ATTENDING MED DIRECTOR PHYS. PHYS. M.D. death. Page . TO FUNERAL page 22d. ADDRESS 220 PHYSICIAN'S TO HOSPITA NAME (Type) director, I NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 25a. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR'S SIGNATURE

VR A15 (4) 15M 7-62

25b. REGISTRAR'S SIGNATURE

(County)

a. IS RESIDENCE

Year

19

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY

PERFORMED?

NO

(State)

22b/ DATE SIGNED

(State)

IF UNDER 24 HRS.

Day

Days

ON A FARM? YES NO L

8 6 7 1 1 Selection of the last of the l ATALARA. PARSONS WEN WESTER AND AND MARKET WILLIAMS AND COMMENTS. MALE BEALTH TO THE STATE OF THE SERVICE STATE OF THE STAT 是自己的,我们就是这有一个人的人的人,但是是这个人的人的。 第二章 WHAT TO BE STONE WAS TONE TO STONE AND A WAY The same of the sa 3-1/22/1966 The Both of the State of Commence ESTERAL VEROLDE LESSEN FREIE L'ARREST PROPERTIES 

## FOR STATE HEALTH DEAT,

O DEPUTY MED EXAMINER: This certificate should be executed within 24 hours after death. If any delay pessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and In any event Within 72 hours after death. TO DEPUTY MED

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VR ALSME (5)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12. USUAL RESIDENCE (Where deceased lived, If institution: Residence before)

|                       | UUU40 MILDICAL   |                               | 75 11/11/166  | COI DEATH                     |                 | 1116                                    | 31                |
|-----------------------|--|-------------------------------|---|-------------------------------|-----------------|---|-------------------|
| 1.                    | PLACE OF DEATH   |                               | 2. USUAL RESIDENC                                     | E (Where deceased lived, If i | nstitution: Res | idence before                           | admission)        |
|                       | a. COUNTY  |                               | a. SIATE<br>New Jer                                   | b. C01                        | UNTY            |   | V                 |
|                       | CHARLES  | MARYLAND                      |   |                               |                 |   |                   |
|                       | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b       | c. CITY OR TOWN (If                                   | outside corporate limits,     | write RURAL e   | nd give neer                            | est town)         |
| 000                   | La Plata   |                               | Irvingt   | on 67                         | _ 2             |   |                   |
| -                     | d. NAME OF HOSPITAL OR INSTITUTION (If not in ho                                 | penital give etreet address   | d. STREET ADDRESS                                     | 011                           |                 | I A IS RE                               | ESIDENCE          |
| 139                   | at theme of most the or most forton (it not in it                                | Aspital, give street eduless) |   |                               |                 | ON A                                    | FARM?             |
| -                     | Physicians Memorial Hosp   |                               |   | rman Place                    |                 | YES                                     | NO .              |
| 3.                    | NAME OF First DECEASED   | Middle                        | Last  | 4. DATE Mor                   | ith             | Day Y                                   | eer 66            |
|                       | (Type or print) JOHN   |                               | CATALDO   | DEATH 1                       | J. J. J. S.     |   | 65                |
| 5.                    | SEX   6. COLOR OR RACE   7. MARRIED  | NEVER MARRIEO 3               | B. OATE OF BIRTH                                      | 9. AGE (In yeer last birthdey |                 | YEAR IFUNO                              |                   |
| ,                     |  | DIVORCED                      | 1-25-1900   | 59 68 Vrs.                    | ) Months D      | ays Hours                               | s Min.            |
|                       | TIGHTE WITTE   | INO OF BUSINESS OR            | 111. BIRTHPLACE (S                                    | tate or foraign country)      | 1 12. CIT       | IZEN OF WHA                             | AT                |
| dur                   | ing most of working life, even if retired)                                       | DUSTRY                        | 1-1   |                               | cou             | INTRY?                                  |                   |
|                       | AINTER   |                               | LIAL  |                               |                 | U.S                                     | A                 |
| 13.                   | . FATHER'S NAME  | , , ,                         | 14. MOTHER'S MAID                                     | EN NAME                       | 0               | /                                       |                   |
|                       | V. (n+   | -A/NO                         | 2   | Me                            | MAGA            | 17/5                                    |                   |
| 15                    | . WAS DECEASED EVER IN U.S. ARMED FORCES? [ 16.                                  | SOCIAL SECURITY NO.   17.     | INFORMANT   | Addr                          | 088             |   |                   |
| (Y                    | es, no, or unkown) (If yes give war or dates of service)                         | V.                            | Haring (  | T.11. 5                       | 12.5            |   |                   |
|                       |  |                               | ThekINE (   | AIALOO - )                    | Ame             | 440000000000000000000000000000000000000 | -                 |
|                       | 18. CAUSE OF DEATH [Enter only one couse per II                                  | ne for (a), (b), and (c).]    |   |                               | 1               | INTERVAL B                              |                   |
|                       | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6)                                 | Multiple                      | traumatic i   | njuries                       |                 |   |                   |
|                       | 8120   |                               |   |                               |                 |   |                   |
|                       | Conditions, If any, which  |                               |   |                               |                 |   |                   |
|                       | gave rise to immediate (b)   |                               |   |                               |                 |   |                   |
|                       | causa (a), steting the DUE TO  |                               |   |                               |                 |   |                   |
|                       | underlying cause last. (c)   |                               |   |                               |                 |   |                   |
| NO.                   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU                                   | ITING TO DEATH BUT NOT RELA   | TEO TO THE TERMINAL I                                 | DISEASE CONDITION GIVEN       | N PART 1(a)     |   | AUTOPSY<br>ORMEO? |
| ATI                   |  |                               |   |                               |                 | YES X                                   | NO                |
| MEDICAL CERTIFICATION | 20a. EXTERNAL CAUSE WAS   20b. L   | PESCULE NOW INTERV OCCIL      | DDED /Enter nature of                                 | Finlury in Part I or Part II  | of-Item 18.)    | T-MAN-                                  | 110               |
| RTI                   | PRIMARY SO OF CONTRIBUTING CAUSE OF DEATH.                                       | escribe how followed          | "River Brid   | ge on Highway                 | 301 H           | Lghway                                  | and               |
| GE                    | ran  | into light pol                | .e  |                               | 7-              |   |                   |
| CAL                   | 20c. TIME OF INJURY Month, Day, Year   20d. II                                   | NJURY OCCURRED 120e. PLAC     | CE OF INJURY (Homa, fa<br>ry, street, office bldg., e |                               | (Coun           | ty)                                     | (State)           |
| 8                     | 8:01 xxxxx. 1-17 19 65 While at work   | NOT WHITE FEET                | Bridge  | 10.)                          | CHAT            | RLES                                    | MD.               |
| Σ                     |  |                               |   | Increation . Inc              |                 | and in my                               |                   |
|                       | 21. I certify that I took charge of the rem                                      | No.                           |   |                               | quiry [],       |   | Ophilon           |
|                       | death resulted from: Natural causes  | , Accident X, Suid            | cide, Homici  | de 🔲, Undetermine             | d manner [      |   |                   |
|                       | 000  |                               | CHIEF MEDICA  | L EXAMINER X                  |                 |   |                   |
|                       | ACTUAL // 8 TO When  |                               | M.D. ASSISTANT ME                                     | OICAL EXAMINER                |                 | 22. DATE                                | ESIGNED           |
|                       | SIGNATURE  |                               | DEPUTY MEDIC  | AL EXAMINER                   |                 | 1 17                                    | 66                |
|                       | EXAMINER'S RUSSELL S. FISH   | IER. M.D.                     |   | t, city, town, or county)     |                 | 1-17-                                   | -00               |
| 00                    | 1.31-7   | 1 23c. NAME OF CEMETERY       |   | 23d. LOCATION (City.          | town or cour    | ity) (                                  | (State)           |
| 238                   | a. BURIAL, CREMATION, 23b. OATE THEREOF  | 23C. NAME OF CEMETERY         | / /   | -40 +/) O                     | 4 . 1 . 2       | 11/                                     | )                 |
|                       | DURIAL 1-21-66   | HOLY) CORI                    | elchre  | AST URA                       | N68,            | 10,                                     |                   |
| 24                    | FUNERAL DIRECTOR   | AODRESS                       | 25a. RE   | 20                            | REGISTRAR'S     | - 1/                                    |                   |
|                       | Filowall Domanostal  | onlihonte Her                 | CLF ONTAN   | 19 1966                       | Chanley         | Judge                                   | -                 |
| 1                     | -// WONTH TINIBLOST IN   | CYTHING IN                    | 1   |                               |                 | 11-11-                                  |                   |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. certificate be executed within 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death Page 4 may be retained by the hospital or attending physician.

> VR A15 (4) 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| 1. PLACE OF DEATH a. COUNTY  | 2. USUAL RESIDENCE (Where deceased lived, If Institution: R      | esidence before admission)                   |
|--|--|--|
| Charles MARYLAND   | a. STATE Maryland b. COUNTY Ch                                   | arles  |
| b CITY OR TOWN (If outside cornorate limits   C   FNCTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporete limits, write RURAL        |  |
| write RURAL and give nearest town)  La Plata   | Wal (D   | 181  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   | Welcome (Rural)  | e. IS RESIDENCE                              |
|  | )  | ON A FARM?                                   |
| Physicans Memorial Hospital  |  | YES A NO                                     |
| 3. NAME OF First Middle  | Last 4. DATE Month OF  | Day Year                                     |
| (Type or print) Cussell Gordon   | CROST DEATH  | ( 19 ( 6                                     |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8   | 8. DATE OF BIRTH 9. AGE (In years IF UNDER last birthday) Months | 1 YEAR IF UNDER 24 HRS.<br>Days Hours   Min. |
| WIDOWED X DIVORCED   | 7 6 1897 68 yrs. Wolldis   | Days Hours With.                             |
| 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR   | 11. BIRTHPLACE (County & State, or foreign country)   12. CI     | TIZEN OF WHAT                                |
| during most of working life, even if retired) Farmer Farming   |  | OUNTRY?                                      |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |  |
| William Conft  | Fannia D. Davis  |  |
| William Croft 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17.  | Fannie B. Davis  |  |
| (Yes, no, or unkown) (If yes give war or dates of service)   |  |  |
| No    213-16-2495  N   | Mr. Wilson Croft -Son-LaPl                                       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  | INTERVAL BETWEEN ONSET AND DEATH             |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   |  |  |
| 33 / X DUE TO 11 A   |  | . , ,  |
| Conditions, If any, which ) (b) 1 ty new for   |  | 1 4 days                                     |
| gave rise to immediate   | Α  |  |
| cause (a), stating the   | Carles Justine .   |  |
|  | TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)         | 19. WAS AUTOPSY                              |
| Tall Diagram   |  | YES ND D                                     |
| 20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY DCCU   | JRRED. (Enter nature of injury in Pert I or Part II of Item 18.  | 1 44   |
| PARTII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH SIGNIFICANT CONTRIBUTING TO DEATH SIGNIFICANT CONTRIBUTING TO THE SIGNIFICANT CONTRIBUTION CONTRIBUTING TO THE SIGNIFICANT CONTRIBUTION CONTR | miles (Enter Install of Injury in 1911 to 1911 to 1911)          |  |
|  | CE DF INJURY (Home, farm,   20f. (City or town) (Cou             | inty) (State)                                |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE 19 While at work at work  | ory, street, office bldg., etc.)                                 | inty) (otato)                                |
| p.m. 19 at work at work  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from  | 13 , 1965, to / 7 , 196  | that (I) (we) last                           |
| saw the deceased alive on 1965, and that   | t death occurred at 10.10 M, from the causes and on t            |  |
| 22a. SIGNATURE   |  | ATE SIGNED                                   |
| 1 ( ttuo h, haiters M.D  | O. PHYS. MED. STAFF DIRECTOR PHYS.                               | 7/1966                                       |
| 22c. PHYSICIAN'S   | 22d, ADDRESS   |  |
| NAME (TYPE) ARTURO M. MONTENZO   | Les MATA, Md.  |  |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY  | Y OR CREMATORY   23d. LOCATION (City, town or co                 | unty) (State)                                |
| Burial (Specify) 1/11/1966 Methodist   | Cemetery Dentsville, M   | id.  |
| 24. FUNERAL DIRECTOR ADDRESS   | 25a. REC'D BY REGISTRAR 25b. REGISTRAR                           |  |
| Arehart Funeral Home, IncLa Plata  | a, Ma MAN 14 1966 Ithurle  | Outra  |
| The state of the s | ) DMENN T - 1200   1200  | 1 Marchael                                   |

|               |                   |                  | 00628 ** ********************************* |
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|               |                   |                  |  |

# FOR STATE HEALTH DEPT O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

|               | 00627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |
|---------------|--|
| 1.            | PLACE OF DEATH a. COUNTY  2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE  b. COUNTY  MARYLAND  |
|               | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |
|               | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?  YES NO  |
| 3.            | OF CTYPE OF PRINTY DEATH 1 31 166  |
| 5.            | Wale Negro- WIDOWED DIVORCED 6-28-1903 (last brighday) Months Days Hours Min.  |
| 10:<br>du     | a. USUAL OCCUPATION GIVE kind of work done rolling for working life, even if retired)  10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country)  11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY2  13. FATHER'S MAME 1. 14. MOTHER'S MAIDEN NAME  |
|               | 5. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address Address   |
|               | es, no, or unkówn) (If yes pive war or dates of service) 218-16-3183 ELSIE HARRIS DAVIS THE COMPANY OF THE COMP |
| 1             | PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  ONSET AND DEATH  |
| 100           | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO  (b)  DUE TO  (c)   |
| CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO PART I OF PART II OF PA |
|               | PRIMARY OF CONTRIBUTING CAUSE OF DEATH.  |
| MEDICAL       | 20c. TIME OF INJURY Month, Day Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, lambdar, etc.)   4   4   4   4   4   4   4   4   4  |
|               | 21. I certify that I took charge of the remains described above, held an Autopsy, Inspection inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner  |
|               | ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER ( 22. DATE SIGNED   |
|               | EXAMINER'S PUTULE LEN HOROUS (Street, city, town, or county) 13/66   |
| 23            | (REMOVAL (Specify) 2/5/1966 Mit Hopedametery   |
| 22            | ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |

Pomon Key

DATE FEB 9

1966

VR A15ME 3500 4-64

director. Page 4 shour retained for your files.

TO DEPUTY MEDIC

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Funeral Home

COSC 1 ... MEDICAL EXAMINES SEEL SEATHERN DEVIN 1 ( sind 2/5/1916 2/19 They Lowery ... MARYLAND STATE DEPARTMENT OF HEALTH

|               |   | ORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CATE OF DEATH  |  |  |  |  |  |
|---------------|---|---|--|--|--|--|--|
| 1             | PLACE OF DEATH  a. COUNTY  Charles  MARYLE  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission)  e. STATE  Maryland  b. COUNTY  Charles |  |  |  |  |  |
|               | b. CITY OR TOWN (if outside corporete limits, write RURAL end give nearest town)  La Plata  |   |  |  |  |  |  |
|               | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street eddress  Physicans Memorial Hospita                                 | ON A FARM?  |  |  |  |  |  |
|               | NAME OF First Middle DECEASED (Type or print) ROBERT E.   | DAVIS  4. DATE Month JOY 1866.  |  |  |  |  |  |
| ]             | 6. COLOR OR RACE 7. MARRIED MINEYER MARRIED White WIDOWED DIVORCED ON USUAL OCCUPATION (Give kind of work   1Db. KIND OF BUSINESS OR IN | October 1,1901 64 yrs. Months Doys Hours Min.   |  |  |  |  |  |
| de            | one during most of working life, even if retired) <u>Motor Equipment Operator-Md.St</u> FATHER'S NAME                                   |   |  |  |  |  |  |
| 15<br>(Y      | Robert H. Davis  . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (If yesgive wer or dates of service) 212-38-2897     | Agnes M. Henderson Address Mr. LeRoy Davis-Nanjemoy , Maryland  |  |  |  |  |  |
|               | 18. CAUSE OF DEATH [Enter only one couse per line foc. (e), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)            | NARY OCCLUSION INTERVAL BETWEEN   |  |  |  |  |  |
|               | Conditions, if eny, which gove rise to immediate cause  | MAS RENAL DISEASE 14R   |  |  |  |  |  |
| -             | (e), stetling the underlying DUE TO Course lest.  | HR4-Sele  BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY                                |  |  |  |  |  |
| CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH   | PERFORMED? YES NO   |  |  |  |  |  |
|               |   |   |  |  |  |  |  |
| MEDICAL       | 20c. TIME OF INJURY Month, Dey, Yeer   2Dd. INJURY OCCURRED   2  While   Not While   et work   et work                                  | De. PLACE OF INJURY (Home, Ierm, 2Df. (City or town) (County) (Stete) tectory, street, olfice bldg., etc.)                    |  |  |  |  |  |
|               | 21. I certify that (I) (this pospital) attended the deceased saw the deceased alive on  | that death occurred at M, from the causes and on the date stated above.   |  |  |  |  |  |
|               | 220. SIGNATURE Alelen   | M.D. ATTENDING MED. STAFF PHYS. 2/1/1960  |  |  |  |  |  |
|               | 22c. PHYSICIAN'S E J.FOFLEN   | Maryland La Plata, Maryland   |  |  |  |  |  |

Nanjemoy Baptist

Cemetery

2SFEBDAY

DATE

REGISTRAR 25b.

Nanjemoy

REGISTRAR'S SIGNATURE

Maryland

TO HOSPITA A ATTENDING PHYSICIAN: The law requires that the death certificate be executed thin 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. VR A15 (4 1SM 7-62

REMOVAL (Specify)
Burial

2/2/1966

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.

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7 ( Letter with all Figuration Ferbrial Mospital Estat House 2 1 TAKEOS CONTRACTOR TOREOS edition also Lucioner 1,190 Other Note: Quipplent Operator-Md.St. Hoads / Brayton , vi. 1 U.S.M. nostopest is the 212-38-2697 Ar. Lodoy Davis-tin Seroy, Maryland TO THE RESIDENCE OF THE PARTY O bnelvis I. saeft al District , voice has president transcript on the book to be be been all the bear Arehard Panerel Home, Inc. with Flatta, Md. T. He. 006

|           | MARYLAND STATE DEPARTMENT OF HEALTH                               |               |
|-----------|---|---------------|
| VISION OF | STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMOR | E 1, MARYLAND |
| 29        | CERTIFICATE OF DEATH  | 00618         |

| 00090   | OLKIII IOAT                            | L OI DEAII  |  |                            | HUDIA                                     |
|---|--|---|--|----------------------------|---|
| PLACE DF DEATH     a. COUNTY  |  |   | CE (Where deceased lived, If i             |                            | esidence before admission                 |
| Charles   | MARYLAND                               | a. STATE<br>Maryla:                                   | nd Char                                    | 100                        |   |
| b, CITY OR TOWN (if outside corporate limit   |  |   | outside corporate limits, w                |                            | and give nearest town                     |
| write RURAL and give nearest town)  | 6-Hours                                | Rison   |  | 08                         | 7 - 1                                     |
| d. NAME OF HOSPITAL DR INSTITUTION (if no   | ot in hospital, give street address)   | d. STREET ADDRESS                                     |  | 0 -                        | e. IS RESIDENC                            |
| Physicians Memorial   | LaPlata Md.                            | a. STREET ADDRESS                                     |  |                            | ON A FARM? YES NO W                       |
| 3. NAME OF First DECEASED (Type or print) Rudolph   | Middle<br>Digg                         | Last  | 4. DATE Mon OF DEATH 1-2                   | o-66                       | Day Year<br>19                            |
| 5. SEX 6. COLOR OR RACE 7. MA   | RRIED NEVER MARRIED 1                  | 8. DATE OF BIRTH                                      | 9. AGE (In years                           | IF UNDER 1                 | YEAR IF UNDER 24 HR                       |
| Male Negro wid  | DOWED DIVDRCED                         | 3-22-28   | last birthday<br>37 yrs.                   |                            | Days Hours Min                            |
| during most of working life, even if retired) etired-US.Govt.   | 10b. KIND OF BUSINESS DR<br>INDUSTRY   | Chicama   | ounty & State, or foreign count<br>UXIN Md | ry)   12. CII<br>COI<br>US | TIZEN OF WHAT<br>UNTRY?<br>A              |
| 13. FATHER'S NAME   |  | 14. MDTHER'S MAIL                                     |  |                            |   |
| Park Diggs  |  | Rachel  | Jordan                                     |                            |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes give war or dates of service  | 16. SOCIAL SECURITY NO.   17.          | INFORMANT   | Addr                                       | ess                        |   |
| (Yes, no, or unkown) (If yes give war or dates of service   | 213-24-408 Ra                          | chel Digg   | s-Sister,Ri                                | son M                      | d.  |
| 18. CAUSE OF DEATH [Enter only one cause  | e per line for (a), (b), and (c).]     |   |  |                            | INTERVAL BETWEEN                          |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  | Gastro-enteriti                        | a Manta   |  |                            | ONSET AND DEATH                           |
| 09/0  | ZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZ | S ACULE   |  |                            | Days                                      |
| Conditions, If any, which   | Winel Infecti                          |   |  |                            | 7-Days                                    |
| gave rise to immediate (b)  | Viral Infecti                          | 011   |  |                            | 1 - Days                                  |
| cause (a), stating the DUE TO   |  |   |  | 100                        |   |
| underlying cause last. (c)  |  |   |  |                            |   |
| PARTILOTHER SIGNIFICANT CONDITIONS COM<br>Malnutrition  | NTRIBUTING TO DEATH BUT NOT RELA       | TED TD THE TERMINAL (                                 | DISEASE CONDITION GIVEN II                 | N PART 1(a)                | 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO X |
| PARTILOTHER SIGNIFICANT CONDITIONS COM Malnutrition  20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCU          | RRED. (Enter nature of                                | Injury In Part I or Part II                | of Item 18.)               |   |
|   |  |   |  |                            |   |
| 2   | factor                                 | CE OF INJURY (Home, fa<br>ry, street, office bldg., e |  | (Coun                      | nty) (State)                              |
| Hour a.m.   | While Not While at work                | The state of a supplier of                            | ,  |                            |   |
| 21. I certify that (I) (this hospital) a  |  | -20-66  | 9 to 1-20-0                                | 56 19                      | _, that (i) (we) las                      |
| saw the deceased alive on 1 - 20 -  |  | ,   | 7P M, from the causes                      |                            | . A                                       |
| 22a. SIGNATURE  | , and that                             |   | III, ITOM the odoses                       |                            | TE SIGNED                                 |
| 150   | 1 1                                    |   | MED. STAFF                                 | 1 1-2                      | 21-66                                     |
| 22c/ PHYSICIAN'S  | farew M.D                              | 22d. ADDRESS  | DIRECTOR   PHYS.                           | 11                         |   |
| NAME Grames E. Andre  | ews MD                                 | India   | n Head Md.                                 |                            |   |
| 23a. BURIAL CREMATION, 23b. DATE THEREO PREMOVAL (Specify)  | of aluander                            | or CREMATORY  | 23d. LOCATION City,                        | town or cour               | nty) nd state)                            |
| 24. FUNERAL DIRECTOR  | ADDRESS                                | New 25a. REC  | 0.0 1000 00                                | REGISTRAR'S                | SIGNATURE                                 |
| WANSON Y JENKINS  | C 48046AR                              | ve DATE IV  | 26 1966                                    | Agrican                    | Judge.                                    |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR AI5 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00630 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY MARYLAND Charles Maryland Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) Bryantown Bryantown e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS YES NO 3. NAME OF Middle 4. DATE First Month OF DEATH DECEASED M 1866 George Faucett Jan. 3 (Type ar pnnt) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Caucasian 8 Oct. 1882 Male WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? BETAIL DERSON. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Address RINIAN 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dates of service) 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Coronary IMMEDIATE CAUSE (a). DUF TO Canditions, if ony, which gove Some Hypertension Past 3 weeks rise to immediate cause (a), DUF TO stoting the underlying couse Generalized Arteriosclerotic heart disease Years WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL (City or town) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (Stote) 20c. TIME OF INJURY Manth, Doy, Year Haur o.m. foctory, street, affice bldg., etc.) While Nat While at work ot work 2] I certify that (I) (this hospital) attended the deceased from 19 Jan. 1963, to 3 Jan. , 19.66, that (1) (we) last saw the deceased alive an 31 Dec. 1965, and that death accurred at a transfer fram causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. Jan. 1966 M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Arthur O. Wooddy, M. D. La Plata, Maryland

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town)(

24. FUNERAL DIRECTOR

23a. BURIAL CREMATION

REMOVAL (Specify)

**ADDRESS** 

2So. REC'D BY REGISTRAR 1966

2Sb. REGISTRAR'S SIGNATURE

VR A15 (4) 20 M 1/66

equted within 24 haurs after death

the death certificate be

PHYSICIAN: The law requires that

Page 4 may be retained by the haspital or attending physician.

O FUNERAL DIRECTOR: After this certificate

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State Dept. af Health prior to

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. executed within 24 hours after death. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician.

> VR AI5 (4) 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION DF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

|               | 00031  | CERTIFICATI                        | E UP DEATH                      |                                       | 0.0620                           |
|---------------|--|------------------------------------|---------------------------------|---------------------------------------|----------------------------------|
| 1.            | PLACE DE DEATH (   |                                    |                                 | Where deceased lived, If institution: | Residence before admission)      |
|               |  | MADVIAND                           | a. STATE                        | b. COUNTY                             | CHAPIES                          |
| -             | b. CITY OR TOWN (if outside corporate limits,            | MARYLAND   c. LENGTH OF STAY IN 1b | C CITY OR TOWN (If out          | side corporate limits, write RURA     | at and give nearest town)        |
|               | write RURAL and give nearest town)                       | C. CENGIII OI GIAT III 22          | 11                              |                                       | L dild Bird ilegious commy       |
|               | LIB GIATA  | Iday                               | HUGHE                           | SUILLE                                | 08-1                             |
| ,             | d. NAME OF HOSPITAL OR INSTITUTION (If not in h          | iospital, give street address)     | d. STREET ADDRESS               |                                       | e. IS RESIDENCE<br>ON A FARM?    |
| -             | Physicians Memorial                                      | lase P.                            |                                 |                                       | YES NO                           |
| 3.            | NAME OF First  | Middle                             | Lact I.A.                       | . DATE Month                          | Day Year                         |
| J.            | DECEASED   | Middle                             | Last 4.                         | DF                                    | 0 -                              |
| -             | (Type or print) Lawin                                    |                                    | JOOD                            | DEATH AN                              | 9 1965                           |
| 5.            | SEX 6. COLOR OR RACE 7. MARRIED                          | NEVER MARRIED 8                    | 8. DATE OF BIRTH                |                                       | R 1 YEAR IF UNDER 24 HRS.        |
| 1             | MALE CAU WIDOWED   | DIVORCED                           | Det-26 189                      | last birthday) Months                 | Days Hours Min.                  |
|               | A. USHAL OCCUPATION (Give kind of work done ) 10h K      | KIND OF BUSINESS OF                | 1 11. BIRTHPLACE (Count         |                                       | CITIZEN OF WHAT                  |
| dur           | ring most of working life, even if retired)              | UNDUSTRY                           | Characa                         |                                       | COUNTRY?                         |
| 4.0           | TAKINING 1 +   | HAKMER                             | KIASGOW, -                      | OCOTIAND I                            | U. D.H.                          |
| 13.           | . FATHER'S NAME  |                                    | 14. MOTHER'S MAIDEN             | NAME                                  |                                  |
| 6             | dWIN COURTNEY (5000                                      | SR.                                | KATheill                        | ME Gillepsii                          |                                  |
| 15            | . WAS DECEASED EVER IN U.S. ARMED FORCES?   16.          | SOCIAL SECURITY NO.   17.          | INFORMANT                       | Address                               |                                  |
| (Ye           | es, no. or unkown) (If yes give war or dates of service) |                                    |                                 | Frod Hughes                           | villa Md                         |
|               | No 1 - 218   | 111111                             | S. IREASE                       | 0000 110911-                          | VIIIC, THE                       |
|               | 18. CAUSE DF DEATH [Enter only one cause per I           | Ine for (a), (b), and (c).]        |                                 |                                       | INTERVAL BETWEEN ONSET AND DEATH |
|               | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)         | ( , V, A. )                        | EULPE                           |                                       | ONSET AND DEATH                  |
|               | 2211   | 11                                 |                                 |                                       | 1                                |
|               | Conditions It any which                                  | Hypetic                            |                                 |                                       | 11000                            |
|               | Conditions, If any, which gave rise to immediate (b)     | 1 To En lunge                      | No.                             |                                       | 197                              |
|               | cause (a), stating the DUE TO                            | 2 11 1                             |                                 |                                       |                                  |
|               | underlying cause last. (c)                               | Jani Holes                         | 2 coscleposis                   |                                       |                                  |
| ON            | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBU           | UTING TO DEATH BUT NOT RELA        | TED TO THE TERMINAL DISE        | ASECONDITION GIVEN IN PART 1(2        | 1) 19. WAS AUTOPSY               |
| CERTIFICATION | NV   | ms .                               |                                 |                                       | PERFORMED?                       |
| IFIC          | 20a. ACCIDENT WAS UNDERLYING []   20b.                   | DECORIDE HOW INTURY COOL           | INDED (Finter nature of Int     | Dark I or Dark II of Itom 1           | YES NO                           |
| ERT           | OR CONTRIBUTING CAUSE OF DEATH                           | DESCRIBE HOW INJURY OCCUP          | RRED. (Enter nature of inju     | ury in Part I or Part II of Item 1    | 8.)                              |
|               | (IF EITHER, NOTIFY MEDICAL EXAMINER)                     |                                    |                                 |                                       |                                  |
| MEDICAL       |  | INJURY OCCURRED   20e. PLAC        | CE OF INJURY (Home, farm,       | 20f. (City or town) (Co               | ounty) (State)                   |
| E01           | Hour e.m. While  | a - MOT AMULIE -                   | ry, street, office bidg., etc.) |                                       |                                  |
| Σ             | p.m. 19 at work  | rk at work                         | - 10 1                          |                                       | 11                               |
|               | 21. I certify that (I) (this hospital attended           | / .                                |                                 |                                       | that (I) (we) last               |
| -             | saw the deceased alive on 1 9                            | 1966 , and that                    | death occurred at 5.4           | M, from the causes and on             | the date stated above.           |
| 1             | 22a. SIGNATURE   | 1                                  |                                 | 22b.                                  | DATE SIGNED                      |
|               | Muan M. Ms   | JEW M.D.                           | ATTENDING MED.                  | ECTOR PHYS.                           | 1-9-66                           |
|               | 22c. PHYSIOLAN'S   | Ol Co-C                            | 22d. ADDRESS                    | CION C FRIS. C I                      | , , ,                            |
|               | NAME (Type) A Stup M M                                   | tratures                           | Med                             | 2 had                                 |                                  |
|               | 1/14Abo 11·11  | 1041450                            | 100                             | 5                                     |                                  |
| 23a           | BURIAL, CREMATION, 23b. DATE THEREOF                     | 23c. NAME OF CEMETERY              | OR CREMATORY                    | 23d. LOCATION (City, town or co       | county) (State)                  |
|               | BURIA! 1-12-66   | IRINITY Mei                        | MORIAL WARDI                    | ENS WALDON                            | F, Md                            |
| 24.           |  | ADDRESS                            | 25a. REC'D E                    | BY REGISTRAR   25b. REGISTRAL         | R'S SIGNATURE                    |
| H             | WATT ZINERAL HOME  | WALDORF                            | MJ parkage 1                    | A soco organi                         | of Out of                        |
| 1             | VIVI TUVERAL ITUILE                                      | NATIONE                            | ATEN T                          | 14 1966 fliare                        | by Jungen                        |
|               |  |                                    |                                 | U                                     |                                  |

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where daceased lived, If Institution: Residence before edmission) a. COUNTY I director. Page or your files. Health a. STATE b. COUNTY Charles Virginia MARYLAND b. CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) c. LENGTH OF STAY IN 1b write RURAL and give neerest town) your dof l Arlington LaPlata S d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? 2010 S. 4th Street Howard Johnson Motel YES NO TO 3. NAME OF Middla DATE Month Yeer DECEASED (Type or print) KRISTINA MURRAY DEATH January 66 19 with th and 3 to 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Female. White ye 5 n 72 h 10/5/65 WIDOWED [ DIVORCED [ 3 10a. USUAL OCCUPATION (Give kind of work 8. Give Pages 1, 2, 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? form PM3. Page done during most of working life, even If retired) none none Md . within w 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Patrick Murray Kathleen Cain event 15. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yas, no, or unkown) | (If yes give wer or detas of service) in pencil in Item 1 Office along with any Patrick Murray DICAL EXAMINER: This certificate should be executed Chevy Chase, Md. none 1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN .5 burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY. and IMMEDIATE CAUSE (a) Interstitial Pneumonitis. removal DUE TO Conditions, if any, which (b) "pending" geva rise to immediate cause lease execute the certificate, writing the standard Examiner's should be forwarded to the Chief Medical Examiner's FUNERAL DIRECTOR: Page 3 should be used as a standard agent. Prior to burial, cremation, or re-DUE TO (a), steting the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY CERTIFICATION PERFORMED? Cleft Lip and Palate. YES K NO 0 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Part I or Part II of item 18.) PRIMARY IT or CONTRIBUTING IT CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Homa, farm, ! 20f. (City or town) (County) (Stata) factory, streat, offica bldg., atc.) Hour a.m. While Not While at work et work 21. I certify that I took charge of the remains described above, held an Autopsy XI. Inspection Inquiry and in my opinion Natural causes X death resulted from: Acciden Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER X DATE SIGNED SIGNATURE DEPUTY DEPUTY MEDICAL EXAMINER 1/16/66 EXAMINER'S Charles S. Petty, M.D. NAME (Type) Address (Street, city, town, or county) 22e. BURIAL, CREMATION. 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Spacify) 40 ā Arlington National Arlington Ellicott City. Md. 24a. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VS. A15ME 5M 9/60 Arlington Va.

CONTRACTOR OF THE STATE OF

executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00022 CEDTIFICATE OF DEATH

|                               | 0000                 | )  |                                    |          | CERTIFICAL                   | E OF DEAT                  | п           |                 |           |            | 121       | 1152      | 9       |
|-------------------------------|----------------------|--|------------------------------------|----------|------------------------------|----------------------------|-------------|-----------------|-----------|------------|-----------|-----------|---------|
| 1. PLAC                       | E DF DEATH           |  |                                    |          |                              | 2. USUAL RESIDE            |             | e deceased liv  |           |            | Residence | before ad | mission |
| Cha                           | arles                |  |                                    |          | MARYLAND                     | Maryland                   | d           | Cha             | rles      | NTY        |           |           |         |
| b. CI                         | TY OR TOW            | N (if outside                            | corporate limi<br>rest town)       | ts,      | C. LENGTH OF STAY IN 1b      | c. CITY OR TOWN (          |             |                 |           |            | L and gh  | ve neares | t town  |
|                               |                      | Road I                                   |                                    | 100      | 5-Mths.                      | Bryans 1                   | Road        | Ma              |           | 09         | 1         |           |         |
| d. N/                         | AME OF HOS           | SPITAL OR INS                            | TITUTION (if n                     | ot In ho | ospital, give street address |                            |             | 110             |           | 0 0 "      | 1         | . IS RES  | IDENCI  |
|                               | 11                   | Shilo                                    | Church                             |          |                              | Indian 15-Shil             | Head.       | Mano            | r         |            |           | ON A F    | NO 3    |
| 3. NAMI                       | E DF                 | DILLIO                                   | First                              | TT TR    | Middle                       | Last                       | on C.       | hurch<br>ME     | Mont      | 3.d        | Day       | Yea       |         |
|                               | ASED or print)       | FAzz+1                                   |                                    | an .     | Nichols                      | Edot                       | DF          |                 |           | 1966       | Juj       | 19        | Ξ.,     |
| 5. SEX                        |                      | 6. COLOR OR                              | RACE 7. MA                         | DRIED    | NEVER MARRIED                | 8. DATE OF BIRIH           |             | 19. AGE (       | n vears   | LIFUNDER   | R 1 YEAR  |           | 24 HR   |
| Fem                           | ale                  | W-US                                     |                                    | OOWED    |                              | 8. DATE OF BIRTH -         | 2           | 7125t b         | irthday)  | Months     | Days      | Hours     | Min.    |
| 1Da. USU/                     | AL OCCUPAT           | ION (Give kind                           | of work done                       |          | ND OF BUSINESS OR            | 11. BIRTHPLACE (           | County & C  | tate or foreign | yrs.      | ()   12 (  | ITIZEN    | OF WHAT   | 1       |
| during me                     | ost of worki         | ng life, even l                          | f retired)                         | 10       | IDUSTRY                      | A CONTRACTOR               |             |                 | m counta, | C          | COUNTRY   | ?         |         |
|                               | mstre                |  | 1                                  | Tal      | loring                       | Bloomf:                    |             |                 |           | US.        | A         |           |         |
| TAI                           | AL 11                | 41111                                    | cuis                               | 10       |                              | 14. MOTHER'S MA            | IDEN NAM    | E Co            | 0.        |            | = 0       |           |         |
| 76                            | IN N                 | W/L                                      | JNI                                | 021      | Υ                            | 1/1/4/A                    | V           | 2,              | 21        | 111)2      | =         |           |         |
| (Yes, no,                     | or unkown)           | (If yes give war                         | MED FORCES?<br>or dates of service | 1        | SOCIAL SECURITYNO. 17.       | ELSTE MAT                  | ohns        | Brva            | Addre     | ss<br>coad | Md        |           |         |
| No                            |                      |  |                                    | 126      | 5-07-4027                    | Elsie M.J.                 | Chu         | Brya<br>rch R   | oad.      | •          |           |           |         |
| 18.                           |                      |  |                                    | e per li | ne for (a), (b), and (c).]   |                            |             |                 |           |            | INTE      | RVAL BET  | WEEN    |
|                               | PART I. DE           | ATH WAS CAU<br>IMMEDIATE                 | SED BY:<br>CAUSE (a)               | Hem      | orrhage Cer                  | ebral                      |             |                 |           |            | 12.       | HOU!      | rs      |
| 3                             | 31X                  |  | DUE TO                             |          |                              | PAGE 1                     |             |                 | 36        | 37 10      |           |           |         |
|                               | litions, If          |  | (b)                                | Art      | erio Sclero                  | sis-Genera                 | al          |                 |           |            | Ind       | defi:     | nit     |
| -                             | rise to<br>e (a), st | 1  | DUE TO                             |          |                              | 779                        |             |                 |           |            |           |           |         |
|                               | rlying caus          |  | (c) S                              | gin      | g Process                    |                            |             |                 |           |            | Ind       | defi:     | not     |
| PART                          | 11. OTHER S          | IGNIFICANT C                             | ONDITIONS CO                       | NTRIBU   | TING TO DEATH BUT NOT REL    | ATED TO THE TERMINAL       | LDISEASE    | CONDITION       | SIVEN IN  | PART 1(a)  | 19.       | WAS AU    | TOPSY   |
| CA                            |                      |  |                                    |          |                              |                            |             |                 |           |            | YE        | PERFORI   | NO N    |
| PART<br>20a,<br>OR C<br>(IF E | ACCIDENT             | WAS UNDERLY                              | ING 🗆                              | 20b. D   | ESCRIBE HOW INJURY OCC       | URRED. (Enter nature       | of Injury I | n Part I or     | Part II o | of Item 18 | 3.)       |           |         |
| OR C                          | ONTRIBUTI            | WAS UNDERLY<br>NG □ CAUSE<br>TFY MEDICAL | OF DEATH<br>EXAMINER)              |          |                              |                            |             |                 |           |            |           |           |         |
|                               |                      | NJURY Month                              |                                    | 20d. IN  | JURY OCCURRED   20e. PL      | ACE OF INJURY (Home,       | farm.   20  | f. (City or     | town)     | (Co        | unty)     | (S        | tate)   |
| WEDICAL<br>20c.               | Hour a.m             | l.                                       |                                    | While    | Not While fact               | ory, street, office bldg., |             | (0.0)           | ,         | (00        |           | ,         |         |
|                               | р.п                  |  |                                    | at work  | at work                      | DE 66                      |             |                 | - (       |            |           |           |         |
| 21                            | 1. I certify         | that (I) (th                             | is hospital) a                     | ttende   | d the deceased from 1        |                            |             | to 1-2          |           |            |           |           |         |
| \$3                           | SIGNATUR             | eased alive                              | on 1-25                            | -00      | 19, and tha                  | at death occurred at       | 2-17N       | Pirom the       | causes    |            |           |           | above   |
| 220.                          | SIGNATUR             | 50                                       |                                    |          |                              | ATTENDING A                | MED.        | ☐ STA           |           | 1-         | 26 - 6    | 56        |         |
| 22c.                          | PHYSICIA             | פיע                                      | a di                               | es       | M.                           | D. PHYS. ADDRESS           | DIRECTO     | R PHY           | S.        |            |           |           |         |
| 1                             | NAME (Ty             |  | es E.A                             | ndr      | ews MD                       | India                      | n Hea       | ad Md           |           |            |           |           |         |
| 23a. BUF                      | RIAL, CREM           | ATION, 23b.                              | DATE THEREO                        | )E       | 23c. NAME OF CEMETER         | V OD CDEMATORY             | 1 024       | LOCATION        | /CIAv. L  |            |           | 104       | nto)    |
| RE                            | MQVAL_(Spe           | clfy)                                    |                                    |          |                              |                            |             | LOCATION        |           |            | - 11      |           | ate)    |
|                               | TAL DIRE             | TOP /                                    | 27/196                             | 00       | Arlington                    | National                   | Ceme        | EGISTRAR        | Arl       | ingt       | on        | Va.       |         |
|                               |                      |  | 77 77                              | 7        | no -Ia Plat                  |                            | N 28        |                 |           | Liverel    |           |           |         |
| ATE                           | nart                 | Finer                                    | a Hon                              | ne.      | nc -la Plat                  | A IVIC   DATED             | N Z O       | IMph            | 1         | - Carlo    | PU X      | The same  |         |

VR A.J.5 (4) 2DM 1/65

THE WILLIAM E WILLIAM SHIPER -The state of the second of the 

FOR STATE DEPT TO DEPUTY KADICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pendi in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 the present of your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trensit permit. File pages 1 and 2 with the State Board of Health, or its designated egent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

#### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS

MEDICAL EXAMINER'S

|      | CERTIF       |           |                 |          |                | ORE 1,   |          | 623      |                          |
|------|--------------|-----------|-----------------|----------|----------------|----------|----------|----------|--------------------------|
|      |              | Mary      | CE (Where 71and |          | ь. cour<br>Ct  | narle    | S        |          |                          |
|      | d. STREET A  | ADDRESS   | lata,<br>norne  |          |                | y Cl     | ub       |          | SIDENCE<br>A FARM?<br>NO |
|      | Last         |           | 4. DATE         |          | Month          |          | Dey      | Your     |                          |
|      | PURD         | Y         | DEAT            | H        | 1-4            | +-66     |          | 19       |                          |
| 8. 0 | ATE OF BIRTH |           |                 |          | E (In yeers    | IF UNDER | 1 YEAR   | IF UNDER | 24 HRS.                  |
| S    | ep. 9        | ,192      | 25              | 40       | birthdey) yrs. | Months   | Deys     | Hours    | Min.                     |
| RY   | 11. BIRTHPLA | CE (State | or foreign      | country) |                | 12. C    | ITIZEN O | F WHAT C | OUNTRY                   |
| -    | ry Clu       |           |                 | Yor      | k              |          | U.S      | .A.      |                          |

| 34 | 1. PLACE OF DEATH  o. COUNTY   |                               | THE RESERVE OF THE PARTY OF THE | CE (Where decessed lived, If institution | on: Residence before edmission) |
|----|--|-------------------------------|--|--|---------------------------------|
|    | Charles  | MARYLAND                      | e. STATE Mary  | land Charl                               | es                              |
| 1  | b. CITY OR TOWN (if outside corporete limits,  | c. LENGTH OF STAY IN 16       | 4  | f outside corporete limits, write RURAI  |                                 |
|    | write RURAL end give neerest town) LaPlata, Md.  |                               | T aP1  | ata, Maryland                            | 08-1                            |
|    | d. NAME OF HOSPITAL OR INSTITUTION (if not in ho   | ospitel, give street eddress) | d. STREET ADDRESS  | aca, maryrand                            | e. IS RESIDENCE                 |
| 2  | Physicians Memorial H  | ospital                       | Hawth  | orne Country C                           | lub YES NO                      |
|    | 3. NAME OF First DECEASED  | Middle                        | Last   | 4. DATE Month                            | Dey Yeer                        |
|    | (Type or print) JAMES  |                               | PURDY  | DEATH 1-4-66                             | 19                              |
|    | 5. SEX 6. COLOR OR RACE 7. MARRI   | ED NEVER MARRIED 8            | . DATE OF BIRTH  | 9. AGE (In yeers   IF UND                |                                 |
|    | male white widow   | ED DIVORCED                   | Sep. 9,192   |  | ns Deys Hours Min.              |
|    | 10e. USUAL OCCUPATION (Give kind of work   | KIND OF BUSINESS OR INDUSTR   |  |  | CITIZEN OF WHAT COUNTRY?        |
|    | done during most of working life, even if retired) Hanager Ha  | awthorne Coun                 | try Club/  | New York                                 | U.S.A.                          |
|    | 13. FATHER'S NAME  |                               | 14. MOTHER'S MAIDEN  |  |                                 |
| 9  | Unkown   |                               | Unkow  | n  |                                 |
|    |  | . SOCIAL SECURITY NO. 17. 1   |  | Address                                  |                                 |
|    | Yes no, or unkown) [Ifyesgive werordates of service] 1943-1964 07  | 71-14-8448 II.                | S. Army Di   | scharge Papers                           |                                 |
|    | 18. CAUSE OF DEATH [Enter only one cause per   |                               | D. Itimy Dr  | beharge rapers                           | INTERVAL BETWEEN                |
|    | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Fat   | ty metamorphosi               | s of the liv   | er. severe                               | ONSET AND DEATH                 |
|    | 5810 DUE TO  | - modumorphosi                | 0 01 00 11   | 01, 50,010                               |                                 |
|    |  |                               |  |  | THE STREET                      |
|    | geve rise to immediate cause   |                               | The state of the s |  |                                 |
|    | (e), steting the underlying DUE TO   |                               |  |  |                                 |
|    | (6)  | NTRIBUTING TO DEATH SUT NO    | T RELATED TO THE TERMIN  | AL DISEASE CONDITION GIVEN IN F          | PART 1(e)   19. WAS AUTOPSY     |
|    | OF THE STATE OF TH |                               |  |  | PERFORMED?                      |
| N  | 20e. EXTERNAL CAUSE WAS   2Db. DESC  | RISE HOW INJURY OCCURED. (E   | inter nature of injury In Pari   | Lor Pert II of item 18                   | YES K NO                        |
|    | PART II. OTHER SIGNIFICANT CONDITIONS CO   | RIOC HOW MODEL OCCURED. (S    | mer notate of injury in rest   | To Form to J                             |                                 |
|    | 0  |                               | CE OF INJURY (Home, form   |  | (County) (State)                |
| 8  | Hour a.m. Whi  | 101 1111110                   | ory, sileer, office blug., etc.  | 1  |                                 |
|    | 21. I certify that I took charge of the re-  | mains described above, he     | ld an Autopsy X.   | Inspection , Inquiry                     | , and in my opinion             |
|    | death resulted from: Natural causes X  |                               |  | Undetermined manner                      |                                 |
|    | 1/1/2  |                               | CHIEF MEDICAL E  | EXAMINER                                 | ATTACK TO STATE                 |
|    | ACTUAL ASSISTANT MEDICAL EXAMINER IX   |                               |  | ICAL EXAMINER X                          | DATE SIGNED                     |
|    | SIGNATURE M.D. DEBUTY MEDICAL EVANIMED 11-5-6  |                               |  |  |                                 |
| 4  | EXAMINER'S Rudiger Breite  | necker, M.D.                  | Address (Street, o   | city, town, or county)                   |                                 |
|    | 22a. SURIAL, CREMATION 22b. DATE THEREOF   | 22c. NAME OF CEMETERY OF      |  | 22d. LOCATION (City, town, or cou        | intry) (Stete)                  |
|    | Burial 1/7/1966  | Arlington Na                  | tional Came  | etery Arlingt                            | on Virginia                     |
|    |  |                               |  | etery Arlingto                           |                                 |
|    | Arehart Funeral Home,  |                               |  | 1966 Scharl                              |                                 |
|    |  |                               | I DAIL .   |  | 1 0                             |

VS. A15ME 5M 7/59

te plan dall musica antoroxida Something the bags of the second second Salthorne Commany of toy hew former to be. 8.8. es 1943-1964 1071-18-448 U.S. Army of Charge Papers atmigate, appendice, vestous 2 Isas its vojantina \ 0001\TVE i Lairuc Boy T Well . Di, sasin Mir. oni, smon Linear June 1

VR A15 (4) 15M 4-64

23d. LOCATION (City, town or county) (State)

Charles

Day

Days

12. CITIZEN OF WHAT

COUNTRY? U.S.A.

Md.

Months

e. IS RESIDENCE

YES

ON A FARM?

Year

1966

Hours |

INTERVAL BETWEEN ONSET AND DEATH

WAS AUTOPSY

PERFORMED?

NO 3

(State)

YES T

1966. that (I) (we) last

DATE SIGNED

(County)

22b.

NO X

Bryans Road, Maryland REGISTRAR'S SIGNATUR

Huntt Funeral Home, Waldorf, Maryland

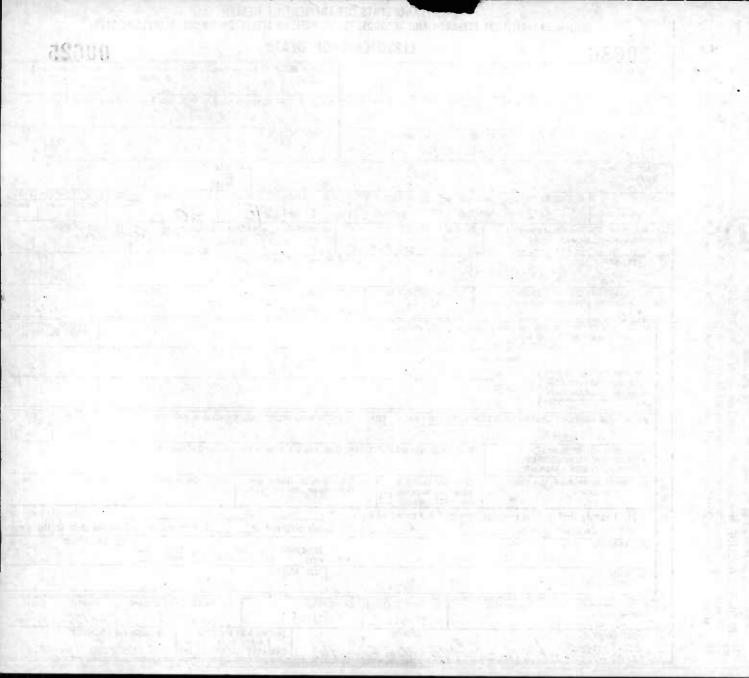
MARYLAND STATE DEPARTMENT OF HEALTH

di ari an Intropoli Initional guardiave on the mark the barrent e rear, a view Teaming is a company to the Best Company of the Best Company (200) LOVE TO SEE DESIGNATION OF SPRINGER OF handward, anol smayth terbodiet to be be be fet farmi Limit same to a training to the total Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|   |                 | 00636   | CERTIFICATE                              | OF DEATH  |  | 00625   |
|---|-----------------|---|--|---|--|---|
|   |                 | PLACE OF DEATH O. COUNTY CHARLES  | MARYLAND                                 | 2. USUAL RESIDENCE (Where o. STATE D.                     | e deceosed lived, if institution: Resid<br>b. COUNTY | ence before admission)  ARIES                 |
|   | t               | o. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                                    | c. LENGTH OF STAY IN 1b                  | c. CITY OR TOWN (If outside                               | corporate limits, write RURAL and g                  | 08-1  |
| 2 | 2               | LNAME OF HOSPITAL OR INSTITUTION (If not in hospital, Thysicians INC.)  |  | d. STREET ADDRESS<br>LA PLATA                             | , Md   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO       |
|   | (               | NAME OF First PECEASED Type or print)  A We's   | Middle Edward                            | Robinson  | DATE Month OF DEATH  9. AGE (In yeors   IF UNDE      | Doy Year  19 6 6  R 1 YEAR   IF UNDER 24 HRS. |
|   | S. S            | M COL. WIDOWED  | NEVER MARRIED   8  DIVORCED   1          | D'ATE OF BIRTH 941875  11. BIRTHPLACE (County & Sto       | last birthdoy) Months                                |   |
|   | duri            |   | FARMING                                  | WHITE PIA   | INS, MD-CHAM   | COONTRY? U.S.                                 |
|   |                 | EdWARD KODINSON   | SOCIAL SECURITY NO. 17. III              | UNKN  | 0 WN   |   |
|   | (Ye             | s, no, or unknown) ((If yes give wor or dotes of service) 2/  1B. CAUSE OF DEATH (Enter only one couse per line for |  | s. Eliza Sn   | with Brandyn   | INTE, MD                                      |
|   |                 | PART I. DEATH WAS CAUSED BY:  4 90 X IMMEDIATE CAUSE (0)  DUE TO  | Loxema                                   | 011   |  | ONSET AND DEATH                               |
| V |                 | Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.                      | Phermone.                                | 131 JER   | H  | 12 days                                       |
| 2 | ATION           | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  | TO DEATH BUT NOT RELATED TO THE          | HE TERMINAL DISEASE CONDITI                               | ON GIVEN IN PART 1(a)                                | 19. WAS AUTOPSY PERFORMED? YES NO             |
|   | A CERTIFICATION | OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | ESCRIBE HOW INJURY OCCURRED. (           |   |  |   |
|   | MEDICAL         | Hour o.m. While p.m. 19 of wor  | Not While focto                          | E OF INJURY (Home, form, ory, street, office bldg., etc.) |  | County) (Stote)                               |
|   |                 | 21. I certify that (I) (this haspital) after saw the deceased alive an 220. SIGNATURE                               | nded the deceased from19 6 , and that    | death accurred at   | M, fram causes and an                                | the date stated abave.                        |
| 1 |                 | 22c. PHYSICIAN'S  | tem M.D                                  | ATTENDING MEE<br>PHYS. DIR<br>22d. ADQRESS                |  | 18/66   |
|   | 230             | NAME (Type) PRILIPO M. BURIAL CREMATION 23b. DATE THEREOF   | MONTE I RO<br>23c. NAME OF CEMETERY OR-C | REMATORY . I  | 23d. LOÇATION (City or Town)                         | (County) (Stote)                              |
| 1 |                 | REMOVAL (Specify)  FUNERAL DIRECTOR   | BRICES (                                 | CHAPE   250. REC'D BY                                     | WALDORF CH   | PARles MD                                     |
| 3 | 4               | when Juniolal Home  | Maldore 1                                | M DATE AN   | 13 1966 Aclies                                       | 2 0   |

executed within 24 haurs after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician arthermoletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs after death. O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate. Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) . 20 M 1/66



TO HOSPITA AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed thin 24 hours after death. Page 7 may be retained by the hospital or attending physician.

IO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please tomove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A15 15M 7-62

| MARYLAND | STATE | DEF | ARTMENT | OF | HEALTH |
|----------|-------|-----|---------|----|--------|
|          |       |     |         |    |        |

|                   | MARILAND SIAIL DEPARTMENT OF THEALTH                      |                  |
|-------------------|---|------------------|
| DIVISION OF STATI | STICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTI | MORE 1, MARYLAND |
| 00637             | CERTIFICATE OF DEATH                                      | MICS             |

| 77 | . PLACE OF DEATH   | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before edmission)      |  |  |  |  |
|----|--|--|--|--|--|--|
| 1  | e. COUNTY Charles MARYLAND   | •. STATE Maryland b. COUNTY Charles  |  |  |  |  |
|    | b. CITY OR TOWN (if outside corporete limits, write RURAL and give neerest town)   | La Plata (Rural)-Spring Hill   |  |  |  |  |
|    | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)   | d. STREET ADDRESS  |  |  |  |  |
| 2  | Physicans Memorial Hospital  | ON A FARM? YES NO TO   |  |  |  |  |
|    |  | ROSSITER 4. DATE Month Day Year OF DEATH January 9, 1966                                   |  |  |  |  |
|    | 5. SEX   6. COLOR OR RACE   7. MARRIED     B   | DATE OF BIRTH 9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.                        |  |  |  |  |
|    | Female   White   WIDOWED   DIVORCED  | 1904 62 yrs.   |  |  |  |  |
|    | done during most of working life, even if tetired)   | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania U.S.A.                    |  |  |  |  |
|    | 3. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME   |  |  |  |  |
| 1  | Wilson Q. Haupt  | Mynn Shindel   |  |  |  |  |
| -  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. 1  | NFORMANT Address MQ.   |  |  |  |  |
| 1  | Yes, no., or unkown) (Ifyesgive werordeles of service) Yes. Mi   | r. C. Frank Rossiter-Husband-La Plata,   |  |  |  |  |
| =  | 18. CAUSE OF DEATH [Enter only one cause per line for (a); (b), end (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  ACUSE OF DEATH (c).]  | 6 ccleesin interval BETWEEN ONSET AND DEATH 10 MINS.                                       |  |  |  |  |
|    | 4201 DUE TO 1  | 0 1 D.   |  |  |  |  |
| 1  | Conditions, if eny, which \ (b) Arterioscleratic   | ardiousuly Disease 34RS.   |  |  |  |  |
| 1  | geve rise to Immediate cause (e), stating the underlying  DUE TO   |  |  |  |  |  |
|    | ceuse last. (c)  |  |  |  |  |  |
|    | PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO  | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |  |  |  |  |
|    | Chronic Choleenstika & Cholelitt   | usis - Wederticuloris; Clay App. YES [ NO ]  |  |  |  |  |
|    | PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO  CONTRIBUTING TO DEATH BUT NO  20a. ACCIDENT WAS UNDERLYING TO DESCRIBE HOW INJURY OCCURED  OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER) | (Enter nature of injury in Pert I or Pert II of item 18.)                                  |  |  |  |  |
|    | Hour e.m. While Not While feet   | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State)                             |  |  |  |  |
| 1  | 21. I certify that (I) (this hospital) attended the deceased from.   | 12-24-6519 to 1-9-65, 19 that (1) (we) last  |  |  |  |  |
| Н  | saw the deceased alive on  |  |  |  |  |  |
|    | 22a SIGNATURE 22b. DATE  |  |  |  |  |  |
|    | ATTENDING MED. STAFF DIRECTOR DIRECTOR DIRECTOR 1-9-66   |  |  |  |  |  |
|    | 220 PHYSICIAN'S HAME (Type) J. PARRAN JARBOE M   | D. LA PLATA, MD.   |  |  |  |  |
|    | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY BURIAL 1/11/1966 Meinity Mer   |  |  |  |  |  |
| -  | DUITAL   1/11/1900   INELITICY MEET  | 25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |
|    | Arehart Funeral Home, Inc La Plate   | TAN 11 1000 Melinete Justes.   |  |  |  |  |
| 1. | michai o runeral nome, incna riado   | a grade i sortili a love i   |  |  |  |  |

Editor of This is sail? as NYMEAGIN Con a margarette de la company sthin afanet .a.s.o \_\_\_\_\_aimeylgames ... Pempeller - constraint ismini days to be in the interest of the inter 327 F 341 - Oracle of - Teorie College (A. 20 - A.) - College (A. 20 Surial Tyldyles Teinity men. Gertens hainerik, de. Licenset Compared Money, int. - as Fiste, Mc. Combine to the FOR STATE
HEALTH DEPT

ME EXAMINER. This certificate should be executed within 24 hours after death. If any delay scessary, scot, are certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 is are funeral Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. director. Page 4 shoul retained for your files. TO DEPUTY ME

2

3

VR A15ME (5) 5M 1/65 Items 18821 Film G373MARYZAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00638 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| Country   CHARLES   Charles   Country   Charles   Char   | S. COUNTY CHARLES  D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  Hamps tead  d. STREET ADDRESS  Physicians Memorial Hospital  D. COUNTY Hamps tead  d. STREET ADDRESS  Physicians Memorial Hospital  D. COUNTY Hamps tead  d. STREET ADDRESS  Physicians Memorial Hospital  D. COUNTY Hamps tead  d. STREET ADDRESS  Physicians Memorial Hospital  D. COUNTY Hamps tead  d. STREET ADDRESS  Physicians Memorial Hospital  D. COUNTY Hamps tead  d. STREET ADDRESS  Physicians Memorial Hospital  D. SOMERS  DEATH 1 19 646  S. SEX  D. COLOR OR RACE   7. MARKIED   SINVER MARKIED   SOMERS  DEATH 1 19 646  S. SEX  D. COLOR OR RACE   7. MARKIED   SOMERS   S |   |   |  |  |  |
|--|--|---|---|--|--|--|
| CHARLES  b. GITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)  J. Plata  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)  Physicians Memorial Hospital  SAMIGE  Physicians Memorial Hospital  SAMIGE  RICHARD  SOMERS  Houckville Road  Vering  SOMERS  SOMERS  SOMERS  SOMERS  Houckville Road  Vering  SOMERS  SOMERS  SOMERS  SOMERS  SOMERS  Houckville Road  Vering  Beat influence  SOMERS   | CHARLES  D. GITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata  d. NAME OF HOSPITAL OR INSTITUTION (if not in bospital, give street eddress) Physicians Memorial Hospital  S. RAME OF HOSPITAL OR INSTITUTION (if not in bospital, give street eddress) Physicians Memorial Hospital  S. RAME OF HOSPITAL OR INSTITUTION (if not in bospital, give street eddress) Physicians Memorial Hospital  S. RICHARD S. SOMERS Physicians Memorial Hospital  S. RICHARD S. SOMERS SOMERS SOMERS SOMERS SOMERS SOMERS SOMERS SOMERS AND THE WINDOWS DIVINGED BUSINESS OR INDUSTRY Months Days Hours Min.  The WINDOWS DIVINGED CONSTRUCTION CONSTRUCTION S. WAS DECREASE FVER IN U.S. AMMED OF SUSINESS OR INDUSTRY S. WAS DECREASE FVER IN U.S. AMMED FORCES? S. WAS DECREASE FVER IN U.S. AMMED FORCES. S. S. AMMED FORCES. S. S. AMMED FORCES. S. S. AMMED FOR THE FORCES. S. S. AMMED F | 1. PLACE DF DEATH   |   |  |  |  |
| D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  La Plata  d. NAME OF OFOSPITAL OR INSTITUTION (if not in hospital, give street eddress)  Physicians Memorial Hospital  Male Physicians Memorial Hospital  Nove Physicians Memorial Hospital Memorial Hospital Hospital Hospital  Nove Physicians Memorial Hospital Hospital Hospital  Nove Physicians Memorial Hospital Hos | D. CITY OR JOWN (if outside corporate limits, write RURAL and give nearest town)  La Plata  d. RAMAGE OF ORSHITAL OR INSTITUTION (if not in hospital, give street eddress)  Physicians Memorial Hospital  3. RAMAGE DF DECEASE  Physicians Memorial Hospital  S. RAMAGE DF DECEASE  BOLERA OR OR RAGE /7. MARRIED MEMORIAL RICHARD  S. SEX   | CUARTEC   |   |  |  |  |
| La Plata d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)  Physicians Memorial Hospital  Note:   | La Plata   A. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)   A. STREET ADDRESS   A. STREET ADDRESS   NO.   | b. CITY OR TOWN (If outside corporate limits.   C. LENGTH OF STAY IN 1b         |   |  |  |  |
| Construction of the process of the   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress)  Physicians Memorial Hospital  3. NAME OF HOSPITAL OR INSTITUTION (IT not in hospital)  3. NAME OF HOSPITAL OR INSTITUTION (IT not in hospital)  3. NAME OF HOSPITAL OR INSTITUTION (IT not in hospital)  3. NAME OF HOSPITAL OR INSTITUTION (IT not in hospital)  3. NAME OF PEECASED  (Physicians Memorial Hospital  3. NAME OF PEECASED  (Physicians Memorial Hospital  NAME OF PEECASED  (Physicians Memorial Hospital  NAME OF PEECASED  (Physicians Memorial Hospital  NAME OF HOUSE NAME OF BUSINESS OR NAME (IT not working provide who work done)  (Physicians Memorial Hospital  NAME OF HOUSE NAME OF BUSINESS OR NAME OF BUSINESS OR NAME (IT not working provide who work done)  (Physicians Name House Name Of House Name Of Canada Name Of Name Of Canada Name Of Canada Name Of Nam |   | Hampstead 06 - 2  |  |  |  |
| Physicians Memorial Hospital    Houckville Road  | Physicians Memorial Hospital  Houckville Road  |   | A STREET ADDRESS I B. IS RESIDENCE  |  |  |  |
| Second Content of the Content of t   | S. MANE OF COLOR OR RAGE   SAMUEL   RICHARD   SOMERS   DEATH   1   19   64   68  | Dhysisiana Mamarial Magaital  |   |  |  |  |
| BEERASE   COLOR OR RACE   7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH   9. AGE (in, years   inf unders) Year   if unders   Year   | SAMIEL   RICHARD   SOMERS   DEATH   1   19 66  |   | Hodekviile Roda   |  |  |  |
| Male   | Mail   | (Type or print) SAMUEL RICHARD  | SOMERS DEATH 1 1 19 66  |  |  |  |
| Maryland   12. cirizen of what   13. father's name   14. Mother's MalDen Name   14. Mother's MalDen Name   15. was because the working life, even if etiled)   15. kinD of Business or   16. social security   17. informant   18. was because the working life, even if etiled   15. was because the working life, even if etiled   15. was because the working life, even if etiled   15. was because the working life, even if etiled   15. was because the working life, even if etiled   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was or dates of service)   15. was because the working life was life for (a), (b), end (c). 1   15. was autopey   15.   | Maryland   12. Cilizen of what   13. BirthPLAGE (state of foreign country)   12. Cilizen of what   13. BirthPLAGE (state of foreign country)   12. Cilizen of what   13. BirthPLAGE (state of foreign country)   13. Cilizen of what   14. MOTHER'S MAIDEN NAME   14. MOTHER'S MAIDEN NAME   14. MOTHER'S MAIDEN NAME   14. MOTHER'S MAIDEN NAME   15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITYNO.   17. INFORMANT   Address   17. Cilizen of what   18. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITYNO.   17. INFORMANT   Address   18. CAUSE OF DEATH LENter only one cause per line for (a), (b), end (c).]   18. CAUSE OF DEATH LENter only one cause per line for (a), (c), end (c).]   Status epilepticus   INTERVAL BETWEEN   ONSET AND CEATH   O   | 5. SEX 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8                            | Q QQ 7 Q7 Q lest birthday) Months   Days Hours   Min.                               |  |  |  |
| Author   Control   Contr   | during most of working life, even if retired)    Industry  | Male White Monte  | 7 X847 yrs.   |  |  |  |
| Robert Somers  | Robert Somers  | during most of working life, even if retired) INDUSTRY                          | COUNTRY?  |  |  |  |
| 15. WAS DECEASED EVER INU.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT   Address   16. SOCIAL SECURITY NO.   17. INFORMANT   Address   18. CAUSE DRY   18. CAU   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes line was or dates of service) 219-01-1779 Mrs. Thelma Somers, Hamsptead, Md.  18. CAUSE DF DEATH [Enter only one ceuse per line for (a), (b), and (c).]  18. CAUSE DF DEATH [Enter only one ceuse per line for (a), (b), and (c).]  18. CAUSE DF DEATH [Enter only one ceuse per line for (a), (b), and (c).]  19. CONDITION (BELL) (b)  | 13. FATHER'S NAME   |   |  |  |  |
| Yes   WW2  | (If yes place war of dates of service)   219-01-1779   Mrs. Thelma Somers, Hamsptead, Md.   18. GAUSE OF DEATH [Enter only one couse per line for (a), (b), end (c).1  | Robert Somers   | Susanna Harrison  |  |  |  |
| Second   S   | See   WW2   219-01-1779   Mrs. Thelma Somers, Hamsptead, Md.   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17.     | INFORMANT Address   |  |  |  |
| PART I. DEATH WAS CAUSED BY:    MMEDIATE CAUSE (e)   | PART I. DEATH WAS CAUSED BY:    MMEDIATE CAUSE (e)   Status epilepticus  |   |   |  |  |  |
| DUE TO  Conditions, if eny, which gave rise to immediate cause (e), stating the underlying couse last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES X NO   20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.  20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.  20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner    ACTUAL SIGNATURE CAUSE IJ, S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)  REMOVAL (Specify) 1-5-66  Wesley 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  | DUE TO  Conditions, if eny, which gove rise to immediate cause (e), stating the underlying ceuse last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITION GIVEN IN PART I(a)  PART III. OTHER SIGNIFICANT CONDITION GIVEN IN PART I(a)  PART III. OTHER  |   | ONSET AND DEATH   |  |  |  |
| Conditions, if eny, which gave rise to immediate cause (e), stating the underlying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Fatty degeneration of liver  Fatty degeneration of liver  Fatty degeneration of liver  20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING COURRED CAUSE OF DEATH.  20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED While Not While at work at | Conditions, if eny, which gave rise to immediate cause (e), stating the underlying couse last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEPTH II OF ITEM 1 (b)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OF COUNTY OCCURRED.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OF COUNTY OCCURRED.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OF COUNTY OCCURRED.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OCCURRED.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OCCURRED.  PART II. OTHER SIGNIFICANT CONDITION OCCURRED.  PART II. OTHER SIGNIFICANT | IMMEDIATE CAUSE (8) Status epilepti   | cus   |  |  |  |
| geve rise to immediate cause (e), stating the underlying ceuse last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or | gove rise to immediate cause (a), stating the underlying couse last.    DUE TO   | 3032 DUE TO   |   |  |  |  |
| Cause (e), stating the underlying couse last.  PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PERFORMED?  YES NO  19. WAS AUTOPSY PERFORMED?  YES NO  20a. EXTERNAL CAUSE WAS PRIMARY TO CONTRIBUTING CAUSE OF DEATH.  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.)  PRIMARY TO CONTRIBUTING CAUSE WAS PRIMARY TO COUNTRIBUTING CAUSE OF DEATH.  20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  P.m. 19 was autopsy YES NO  20a. EXTERNAL CAUSE WAS PRIMARY TO COUNTRIBUTING CAUSE OF INJURY (Home, farm, factory, street, office bldg., etc.)  PRIMARY TO REMOVE A COUNTRIBUTING CAUSE OF INJURY (Home, farm, factory, street, office bldg., etc.)  P. D. 19 et work at work to the work of the remains described above, held an Autopsy XI, Inspection Industry and In my opinion death resulted from: Natural causes XI, Accident INDURY MEDICAL EXAMINER INDURED CAUSE OF INJURY MEDICAL EXAMINER INDURING COUNTRIBUTION (State)  ACTUAL COUNTRIBUTION | Carroll Co.   Co   |   |   |  |  |  |
| Underlying couse last.    Co   | Underlying ceuse last.   (c)   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   19. WAS AUTOPSY PERFORMED? YES \( \) NO \( \)   20a. EXTERNAL CAUSE WAS PRIMARY \( \) Or COUNTRIBUTING \( \) CAUSE OF DEATH.   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   19. WAS AUTOPSY PERFORMED? YES \( \) NO \( \) CAUSE OF DEATH.   20c. TIME OF INJURY Month, Oay, Year of the twork \( \) Not While \( \) Not While \( \) Not While \( \) Not While \( \) Part II took charge of the remains described above, held an Autopsy \( \), inspection \( \), inspection \( \), inquiry \( \), and in my opinion death resulted from: Natural causes \( \), Accident \( \), Accident \( \), Suicide \( \), Homicide \( \), Homicide \( \), Undetermined manner \( \) ACTUAL SIGNATURE \( \) ACCIDENTAL SIGNATURE \( \) ACTUAL    | DHE TO  |   |  |  |  |
| Fatty degeneration of liver  20a. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   CAUSE OF DEATH.  20c. TIME OF INJURY Month, Day, Year Hour e.m. P.m. 19   While at work   at work   at work   at work   at work   at work   Accident   | Fatty degeneration of liver    Patty degeneration of liver   Yes   No  | underlying ceuse last. (c)  |   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   CHIEF MEDICAL EXAMINER   ACTUAL SIGNATURE  | 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   ACTUAL CLUSCOL S. ACCIDENT , ACCIDENT MEDICAL EXAMINER   ACTUAL SIGNATURE SIGN | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA        | TEO TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMEO? |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   CHIEF MEDICAL EXAMINER   ACTUAL SIGNATURE  | 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   ACTUAL CLUSCOL S. ACCIDENT , ACCIDENT MEDICAL EXAMINER   ACTUAL SIGNATURE SIGN | Fatty degeneration of liver   | YES X NO  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   CHIEF MEDICAL EXAMINER   ACTUAL SIGNATURE  | 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   ACTUAL CLUSCOL S. ACCIDENT , ACCIDENT MEDICAL EXAMINER   ACTUAL SIGNATURE SIGN | 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING   20b. DESCRIBE HOW INJURY OCCU | RREO. (Enter nuture of injury in Part I or Part II of Item 18.)                     |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   CHIEF MEDICAL EXAMINER   ACTUAL SIGNATURE  | 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   ACTUAL CLUSCOL S. ACCIDENT , ACCIDENT MEDICAL EXAMINER   ACTUAL SIGNATURE SIGN | 20c. TIME OF INJURY Month, Oay, Year   20d. INJURY OCCURRED   20e. PLA          |   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   CHIEF MEDICAL EXAMINER   ACTUAL SIGNATURE  | 21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection , Inquiry , and In my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   ACTUAL CLUSCOL S. ACCIDENT , ACCIDENT MEDICAL EXAMINER   ACTUAL SIGNATURE SIGN | Hour e.m. While Not While   | ry, street, office bldg., etc.)   |  |  |  |
| death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner   ACTUAL CHIEF MEDICAL EXAMINER X  CHIEF MEDICAL EXAMINER X  DEPUTY MEDICAL EXAMINER 1-3-66  EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)  BURIAL 1-5-66  Wesley Caroll Co. Md.  24. FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR'S SIGNATURE   | death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner   CHIEF MEDICAL EXAMINER   SIGNATURE  SIGNATURE  SIGNATURE  SIGNATURE  SIGNATURE  SIGNATURE  SIGNATURE  SIGNATURE  M.D. ASSISTANT MEDICAL EXAMINER   DEPUTY MEDICAL EXAMINER   1-3-66  Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF  |   | d on Autonou V Inconstign Inquiry and In my opinion                                 |  |  |  |
| CHIEF MEDICAL EXAMINER   ACTUAL SIGNATURE  CEXAMINER'S RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF PURISHER, M.D. Address (Street, city, town, or county)  BURIAL CREMATION, 23b. DATE THEREOF PURISHER CAPTOLL CO. Md.  24. FUNERAL DIRECTOR  CHIEF MEDICAL EXAMINER   22. DATE SIGNED  1-3-66  Address (Street, city, town, or county)  (State)  Carroll Co. Md.  24. FUNERAL DIRECTOR  ADDRESS  25a. REG'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   | CHIEF MEDICAL EXAMINER   ACTUAL SIGNATURE CUSSELL S. FISHER, M.D. ASSISTANT MEDICAL EXAMINER   EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)  REMOVAL (Specify) BURIAL 1 1-5-66  Wesley Carroll Co. Md.  24. FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE   |   |   |  |  |  |
| ACTUAL SIGNATURE 22. DATE SIGNED    M.D. ASSISTANT MEDICAL EXAMINER   22. DATE SIGNED  | ACTUAL SIGNATURE  SIGNATURE  M.D. ASSISTANT MEDICAL EXAMINER  DEPUTY MEDICAL EXAMINER  1-3-66  RAMME (Type)  RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF  REMOVAL (Specify)  BURIAL  24. FUNERAL DIRECTOR  AOORESS  25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  | death resulted from Motore Consolidation (Consolidation)                        |   |  |  |  |
| SIGNATURE  EXAMINER'S RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 1-5-66  Wesley Caroll Co. Md.  24. FUNERAL OREGISTRAR 25b. REGISTRAR'S SIGNATURE   | SIGNATURE  EXAMINER'S RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)  Burial  24. FUNERAL DIRECTOR  ADDRESS  DEPUTY MEDICAL EXAMINER  1-3-66  Address (Street, city, town, or county)  23d. LOCATION (City, town or county)  Carroll Co. Md.  25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   | ACTUAL C. ODD Colored   | 22 DATE SIGNED  |  |  |  |
| EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 1-5-66  Wesley Caroll Co. Md.  24. FUNERAL OIRECTOR ADDRESS 25a. REGISTRAR'S SIGNATURE  | EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. Address (Street, city, town, or county)  23a. BURIAL CREMATION, 23b. DATE THEREOF PROPERTY OR CREMATORY 23d. LOCATION (City, town or county) (State)  REMOVAL (Specify) Burial 1-5-66  Wesley 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  | SIGNATURE CUSSELL S D NOTO  | IVI.U.  |  |  |  |
| 23a. BURIAL CREMATION, 23b. DATE THEREOF PREMOVAL (Specify) BURIAL 1-5-66  Wesley Address 25a. Rec'd by Registrar 25b. Registrar's Signature (State)   | 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)  Burial 1-5-66  Wesley 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   | EXAMINER'S RIISSELL S ETSHER M D  | 1-3-00  |  |  |  |
| REMOVAL (Specify) Burial 1-5-66 Wesley Carroll Co. Md.  24. FUNERAL DIRECTOR ADDRESS   25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE  | REMOVAL (Specify) Burial 1-5-66 Wesley Carroll Co. Md.  24. FUNERAL DIRECTOR  ADDRESS  25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |   |   |  |  |  |
| 24. FUNERAL OIRECTOR AOORESS   25a. REC'D BY REGISTRAR'S SIGNATURE   | 24. FUNERAL DIRECTOR  ADDRESS    25a. REC'D BY REGISTRAR'S SIGNATURE   | REMOVAL (Specify)   |   |  |  |  |
|  | 77 77 77 1 14 tl m 4000 000 0  | 24. FUNERAL DIRECTOR ADDRESS  |   |  |  |  |
| Tippon-Eline Hampstead, Md.   DATEN 7 1966   Miller Judge  |  |   | DATEN 7 1966 Jelsenles Judge  |  |  |  |

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funeral funeral to O DEPUTY MEDIX—EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 i director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pag retained for your files.

PLACE DF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence b. COUNTY Charles a. STATE Maryland Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Pisgah (Rural) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Pisgah (Rural) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARMA State hours NO Z NAME DF DECEASED First Middle Last DATE Month Day Year 1966 THOMPSON JAMES ELMORE January (Type or print) DEATH 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) | Months | Days | Hours | Min. 8. DATE OF BIRTH Male Negro NE WIDOWED DIVORCED 6-14-1902 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR LINDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT Bar Indian Head , Maryland Bartender pages 1 in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Nannie M. Hawkins Charles F. Thompson File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no. or unknown) (If yes give war or dates of service) 218-01-8269 2220 Savannah Terr.S.E. 17. INFORMANT permit. F Mr. Daniel S. Thompson-Brother No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN THISE AMERICA PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) burial-transit | cremation, or | Hemorrhage-Throat DUF TO 6-Mths. Cancer of the Throat Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the . 07 underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? Si c YES NO X or or 2Da. EXTERNAL CAUSE WAS PRIMARY ☐ OF CONTRIBUTING ☐ CAUSE OF DEATH. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 3 should be agent, price MEDICAL 2Dc. TIME OF INJURY Month, Day, Year | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While AL DIRECTOR: Page of or its designated a at work at work Inspection X. Inquiry X, 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion FUNERAL DIRECTOR: f Health or its design Natural causes Accident **Undetermined manner** death resulted from: Suicide Homicide CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER K 1/1/1966 James E. Andrews , M.D. **EXAMINER'S** Andress Istreet, city, fown, or county) . NAME (Type 23a. BURIAL, CREMATION, 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY Buttout (Specify) 10 St. Charles Cemetery . Maryland Glymont 9 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE Funeral Home, Inc .- La Plata . Md. VR ALSME (5)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

- Inclyant 351444 Liantill about 1 en District A. Charpeton will to be only the language to each to be a Jane 1 - section profit 2 to 1 Joseph Selly to tesmo) -- -- --250 PATA D. A. Salar Lang and American dispersion of section of The state of the s are more than a second of the second of the

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| 24 hours after   | in by the funeral   | s I and 2 should<br>ter death.   |
| executed him   | completely filled   | on papers. Pages<br>ithin 72 hours af  |
| oth certificate be   | ng physician and  | in any event w   |
| uires that the dea   | sician.<br>d by the attendir  | permit. Then ple<br>or removal, and  |
| V: The law requ  | or attending phy<br>thas been signe   | he burial-transit<br>urial, cremation,   |
| IG PHYSICIAL   | by the hospital ter this certificate  | thed for use as the Health prior to b  |
| A ATTENDIN   | death. Page ( ) be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the   | should be detac  |
| TO HOSPITAL A ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after | death. Page ( ) be retained by the hospital or attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral | director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any even, within 72 hours after death. |

VR A15 (4) 15M 9/60

#### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| 00010   |  | 110000                        |
|---|--|-------------------------------|
| 1. PLACE OF DEATH   | 2. USUAL RESIDENCE (Whare deceased lived, if institution: Resid          | ence before edmission)        |
| o. COUNTY CATES MARY  | LAND a. STATE TATY and b. COUNTY Ch                                      | detin                         |
| b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STA)                                   |  | e nearest town)               |
| write RURAL and give neerest town)  | A / 1  | /                             |
| /V07/ im 04 194   | 10da/ Imay 68  | - /                           |
| d. NAME OF HOSPITALIOR INSTITUTION (if not in hospital, give street eddre                         | ess) d. STREET ADDRESS   | IS RESIDENCE     ON A FARM?   |
| V   |  | YES NO                        |
| 3. NAME OF First Middle   | Last 4. DATE Month De  | y Year                        |
| (Type or print) William   | Washington DEATH & Danuary 2   | . 3 1966                      |
| S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED  |  | R IF UNDER 24 HRS.            |
| Oldle NEgro WIDOWED DIVORCED  | _ // / // // // // // // // // // // //                                  | Hours Min.                    |
| 1De. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)       | INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN | OF WHAT COUNTRY?              |
| Laborer Son 87ill   | Nanihmon Md U  | . 5                           |
| 13. FATHER'S NAME   | 14. MOTHER MAIDEN NAME   |                               |
| Allie Washington  | Mae Clair  |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO                              | O. 17. INFORMANT Address   | 71                            |
| (Yes, no, or unknown) (Ifyesgive war or detes of sarvice)   | Joseph Wishington Nonjemon Box   | 117 6116                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c)                           |  | INTERVAL BETWEEN              |
| PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) A CULTE CONF                                     | gestine Heart tachere  | ONSET AND DEATH               |
| 1/2 2 2   | 10 C ·   | +                             |
| The DUE TO A CHOICE   | les otre Heart Disease   | 5urs                          |
| Conditions, if any, which gave rise to immediate cause  | arrive of the last   | 27.0                          |
| (a), stating the underlying DUE TO  |  |                               |
| cause lest. (c)   |  |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH                                       | H BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)   | 19. WAS AUTOPSY<br>PERFORMED? |
| El Glargrine Ryht   | toot   | YES NO                        |
| 200. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY C   | OCCURED. (Enter nature of injury in Pert I or Pert II of item 18.)       | 7                             |
| OR CONTRIBUTING ☐ CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)                            |  |                               |
| 20c. TIME OF INJURY Month, Dey, Yeer   2Dd. INJURY OCCURRED                                       | 2De. PLACE OF INJURY (Home, ferm, 2Df. (City or town) (County)           | (Stete)                       |
| 20c. TIME OF INJURY Month, Dey, Yeer 2Dd. INJURY OCCURRED While Not While et work at work at work | factory, streat, office bldg., etc.)                                     |                               |
| P.III. 17   | 1/3 1/3 1/1  |                               |
| 21. I certify that (I) (this hospital) attended the deceased                                      | 114  | , that (I) (we) last          |
| saw the deceased alive on   | nd that death occured at LLAM, from the causes and on the                |                               |
| 22e. SIGNATURE  | ATTENDING MED STAFF  | 22b. DATE                     |
| Trans A Vuolum  | M.D. PHYS. DIRECTOR PHYS.  | 123/66                        |
| 122c. PHYSICIAN'S NAME (Type) Frank A. Susan DI   | 7.D. Rt. Bux 50 Indian Hea   | ed . 02d.                     |
|   | EMETERY OR CREMATORY   23d. LOCATION (City, town or county)              | (Stete)                       |
| BEMOVAL HSDARIFY) June 27 66 Male (   | Same Manianina   | m                             |
| The Funeral Director's SIGNATURE ADDRESS  | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGN                            | NATURE                        |
| 24 FUNERAL DIRECTOR'S SYNATURE  | Onto 1 FFR 1 1966 Charles  | Judge                         |
| ( hehart puneral Home in  | CI SELL IMXTDATEL I I IUU  |                               |

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DERT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY b. CDUNTY Charles Prince George MARYLAND Department after death. c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH DE STAY IN 15. Plata pper Marlboro after d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS delay nd 3 to Page DN A FARM? Physicians Memorial LaPlata State Rural hours Year NAME OF Dorothy Ellen Middle DATE Month Last DECEASED OF -9-66 (Type or print) Berthy Fitin Windsor DEATH 19 within EXAMINER: This certificate should be executed within 24 hours after death. If a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, toold be forwarded to the Chief Medical Examiner's Office along with form. with 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS DATE OF BIRTH Last birthday) | Months | Days Hours Female W-US 8-12-1893 WIDOWED X OIVDRCED N event and 12. CITIZEN OF WHAT 1Da. USUAL OCCUPATION (Giva kind of work done | 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) INDUSTRY Prince Geor -Housewife pages in any Tenent 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown Elizabeth Windsor File Son 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY ND. (Yes, no, or unkown) (If yes give war or dates of service) Alfred E. Windsor-Upper Marlboro Md permit. removal, INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit Coronary Occlusion mmediate IMMEDIATE CAUSE (a) (b) Arterio Sclerosis General Indefinite Conditions, if any, which gave rise to immediate OUE TO causa (a), stating the Indefinite CO used as a to burial, underlying causa last. Aging Process PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Patient was riding in a car with her son when she slumped WAS AUTOPSY certificate, writing the PERFORMED? riding in a car with her son when she slumped DOA.upon arrival at physicians Mem. Hosp. Larla over.she was 3 should be agent, prior 208. EXTERNAL CAUSE WAS PRIMARY OF OF DEATH. CERTIFI 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20d. INJURY OCCURRED | 20a. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While While at work at work DIRECTOR: Page or its designated 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion should Undetermined manner Suicide death resulted from: Natural causes Accident Homicide ge 4 CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED Page ASSISTANT MEDICAL EXAMINER for or FUNERAL f Health o DEPUTY MEDICAL EXAMINER 1-10-66 EXAMINER'S director. retained NAME (Type) James E. Andrews Address (Street, city, town, or county) BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)

Thomas Cemetery Croom

KON

25b. REGISTRAR'S SIGNATURE

VR ALSME (5) 1/65

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REMOVAL (Specify)
Burial

Ritchie Bros. Upper Marlboro. Md.

24. FUNERAL DIRECTOR

TO EAT ALONG PROCESS ENGINEERING n II · · · · · · · · · statel 1/12/66 St. Thomas complet, thomas Litable Pros. Doson Litable, Md.

MARYLAND STATE DEPARTMENT F HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 00642 Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY D. STATE Md Charles b. COUNTY Charles MARYLAND eral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) pe RURAL and give nearest town) should Bryans Road Bryans Road d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM Bryans Road YES NO NAME OF First Middle 4. DATE Month Year B'OoW Day Filled DECEASED Clara E Jan. (Type or print) DEATH 17 1966 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 9. AGE (In years B. DATE OF BIRTH 62 yrs 25March Days Months Hours F Negro Min WIDOWED P DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Naval Propellant PllU.S.Govt. Retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Milliam P. Briscoe Mary C. Marshall 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) 216-22-3696 Mrs. Annie Washington 1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)." INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Conditions, if any, which gave rise to immediate DUE TO cotse (a), slating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE JERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO PA 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (State) (County) factory, street, affice bldg., etc.) Hour a. m. Not while at work of wark 21. I certify that I attended the deceased from ....that I last saw the deceased , and that death accurred at alive an \_M, fram the causes and an the date stated above. DATE SIGNED

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ACTUAL

PHYSICIAN'S

NAME (Type

**FUNERAL DIRECTOR'S SIGNATURE** 

220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY ON ADDRESS

24g. REC'D BY REGISTRAR

22d. LOCATION (City, town, or county)

24b. REGISTRAR'S SIGNATURE

(Stole)

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